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The evaluation of daily activity questionnaire: v1 (parts 1 to 3), outcome measure

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Title	The evaluation of daily activity questionnaire: v1 (parts 1 to 3), outcome measure
Authors	Hammond, A, Tennant, A, Tyson, S and Nordenskiold, U
Type	Monograph
URL	This version is available at: http://usir.salford.ac.uk/30754/
Published Date	2014

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EDAQ:

Evaluation of Daily Activity Questionnaire



© A Hammond, A Tennant, S Tyson, U Nordenskiöld 2016 v1.2 (parts 1-3)

Optional:

NAME: _____ SITE: _____

Date of Birth: ____/____/____ (dd/mm/yyyy)

NHS/Patient Number: _____

Therapist/ Staff Name: _____

Date Completed: ____/____/____ (dd/mm/yyyy)

The Evaluation of Daily Activity Questionnaire (EDAQ): parts 1 to 3.

Adapted by Alison Hammond, Alan Tennant, Sarah Tyson and Ulla Nordenskiöld from the Swedish EDAQ developed by Ulla Nordenskiöld PhD, Sahlgrenska Academy, University of Gothenburg, Sweden.

The EDAQ development and testing was funded by Arthritis Research UK grant 18497. Subsequently, the EDAQ was tested in other musculoskeletal conditions leading to minor modifications of the EDAQ. That work was supported by the United Kingdom Occupational Therapy Research Foundation

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The EDAQ parts 1 and 2 only is available at:

<http://usir.salford.ac.uk/30755/>

The EDAQ User Manual v2 plus Supplements and support materials are available at:

http://usir.salford.ac.uk/view/authors/10108.html#group_monograph

and the lead author's personal website www.profalisonhammond.com (in development)



The EDAQ (Evaluation of Daily Activity Questionnaire) helps us understand about your abilities and problems when doing your daily activities. You may have noticed that using aids, everyday gadgets/ equipment or even different ways of doing things (eg using two hands) reduces some of these problems. Sharing your problems and solutions with us, helps us to help you.

What to do:

There are **two parts**.

Part One asks about how arthritis is affecting you now.

Part Two asks about your ability to do your daily activities in the last two weeks.

Please answer **all** questions.

Please take your time filling in the questionnaire. Bring it with you to your next Therapy appointment.

In Part Two:

Think about your ability in the last **two weeks**. There is an example of how to complete this on page 7. **Please read these instructions and the example before filling in.**

Each page is divided into two sections. Each question should be answered **twice**.

Section A (left side of the page):

How you do the activity **without** using aids/ gadgets, alternate methods (e.g. two handed grip) or help?

- If you do not normally do the activity, tick “**Not Applicable**” (e.g. if you do not drive; or someone else always normally does that activity).
- If you no longer do the activity due to your arthritis (i.e. someone else now has to do it for you), please tick “**Unable to do.**”

Section B (right side of the page)

For **each** activity, please **tick** (✓) in the middle column either:

- **Yes:** if you use an aid/gadget or alternate method, then **always** complete Section B on the right side. Describe how you do it **with** an aid/gadget or alternate method. Then **tick** (✓) how easy/difficult this is.
- **No:** if you do **not** use an aid or alternate method. Do **not** complete the rest of section B.

Or

- **If you have help/ someone else does it for you** because of your health condition, please tick (✓) this column. Do **not** complete the rest of section B.

You can also contact us if you need further help.

Please leave the “score” column blank.

Part 1: Please ✓ the boxes below where relevant.

1. How long have you had your condition? _____ (years)

2. Are you working (paid/ unpaid), in education or planning to return to/start these?

Yes ☐ No ☐

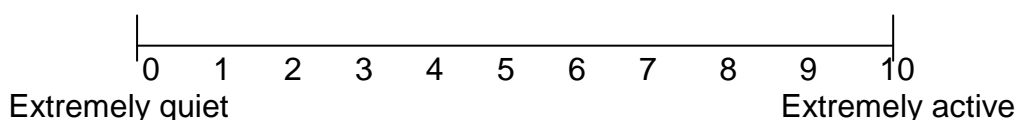
3. Have you taken part in a patient education programme to help you manage your arthritis?

Yes ☐ No ☐

4. If yes, how long was it for (in hours)? _____

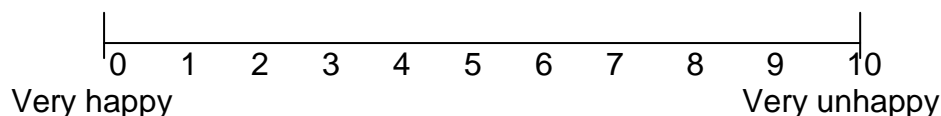
For the following questions we ask you to CIRCLE the number below the line which best reflects your situation at the moment.

1.1. It is said that arthritis can be in an active or quiet phase. In which are you at the moment?

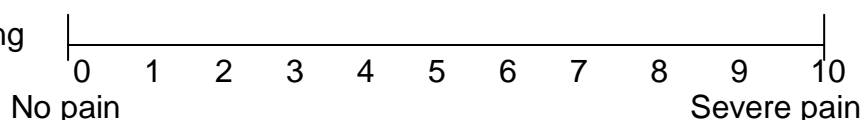


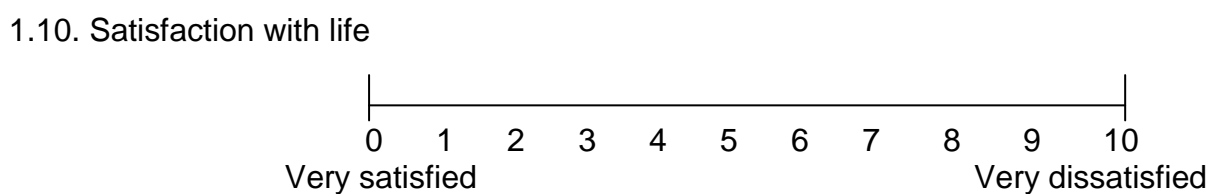
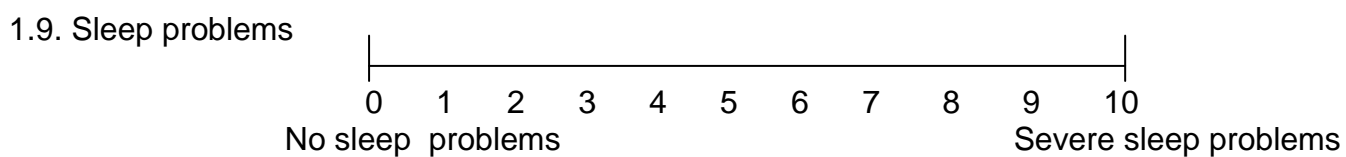
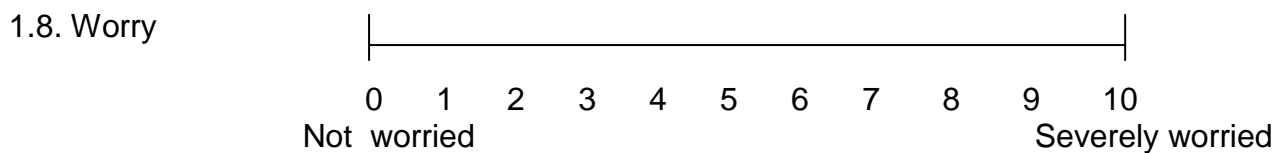
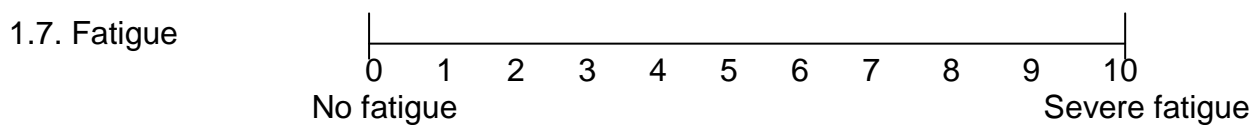
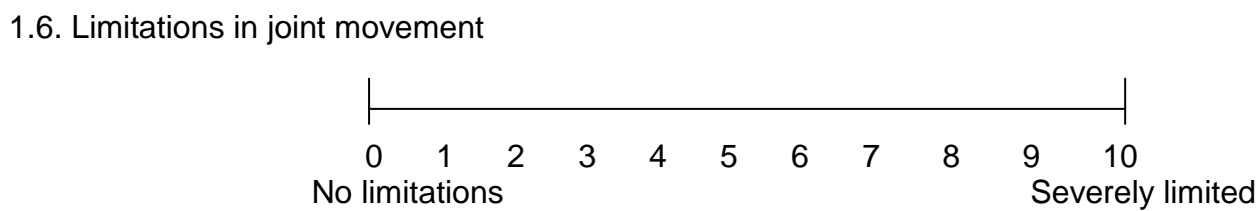
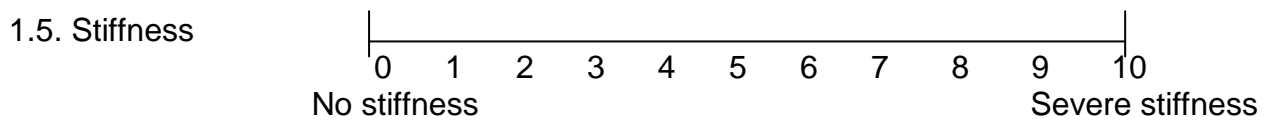
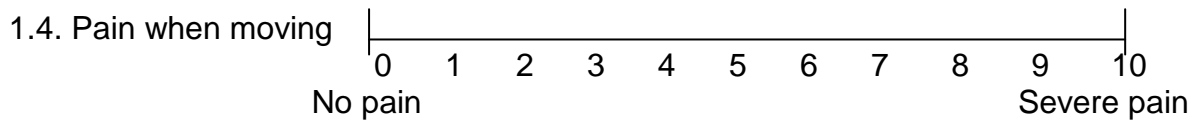
Describe your:

1.2. Mood:



1.3. Pain when resting





Instructions: Example of how to fill in the EDAQ

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:

A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".

B: 'How else do you do it **with** an aid/gadget or alternate method?' Fill in the middle columns. Leave B blank if you tick "no" or "have help."

EXAMPLES: A. How do you do it without an aid/gadget, alternate method or help?							Do you use an aid or other method?			Have help/Some-one does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	
1. Lift a cup/mug		✓						✓								
2. Turn taps				✓			✓				✓					
3. Pull out a plug			✓					✓								
4. Open a jar				✓			✓				✓					
5. Vacuum clean				✓			✓					✓				
6. Put on/take off a coat				✓				✓								
7. Get in/out of bath					✓		✓					✓				
8. Climb ladder					✓			✓								
9. Drive a car	✓															
10. Clean windows				✓						✓						
Total Score: Section A =										Total Score: Section B =						

Part Two: Your ability to do everyday activities

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:

A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".

B: 'How else do you do it **with** an aid/gadget or alternate method?' Fill in the middle columns. Leave B blank if you tick "no" or "have help."

1. EATING / DRINKING	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?						
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	
1.Lift a glass																
2.Lift a cup/mug																
3.Use a knife and fork																
4.Slice food (e.g. bread, cheese)																
5.Get the milk out of the fridge																
6.Open a milk carton/ plastic bottle and pour out																
7.Open a bottle top (e.g. lager)																
8.Open a screw top jar or bottle																
9.Open a tin or a ring-pull can																
10.Open a packet/pouch																
Total Score: Section A =							Total Score: Section B =									

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in both sections:

A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".

B: 'How else do you do it **with** an aid/gadget or alternate method?' Fill in the middle columns. Leave B blank if you tick "no" or "have help."

2. IN THE BATHROOM/ PERSONAL CARE							A. How do you do it without an aid/gadget, alternate method or help?			Do you use an aid or other method?		Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?							
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No	Please describe below which aid/s or other method/s you use?						Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	
1. Get on and off the toilet																				
2. Wipe yourself with toilet paper /clean self below																				
3. Use tampons/ suppositories																				
4. Flush the toilet																				
5. Arrange your clothes after going to toilet																				
6. Wash your hands																				
7. Brush and comb your hair																				
8. Brush your teeth																				
9. Use a tube of toothpaste																				
10. Open a medicine bottle/ blister pack																				
11. Do your make up or shave																				
12. Put on jewellery/watch																				
Total Score: Section A =										Total Score: Section B =										

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?' Fill in the middle columns. Leave B blank if you tick "no" or "have help."

3. GETTING DRESSED /UNDRESSED	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?			Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes No		Please describe below which aid/s or other method/s you use?		Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	
1.Put on / take off a coat																
2.Pull clothes over your head																
3.Put on front-opening clothes																
4.Do up/undo buttons																
5.Pull clothes over your feet																
6.Do up /undo zips																
7.Put on tights/ socks																
8.Take shoes/ boots on and off																
9.Tie shoelaces																
10.Put on/take off gloves																
11.Fasten clothes at the back																
Total Score: Section A =										Total Score: Section B =						

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in both sections:

A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".

B: 'How else do you do it **with** an aid/gadget or alternate method?' Fill in the middle columns. Leave B blank if you tick "no" or "have help."

4. BATHING/ SHOWERING	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1. Get in and out of the bath															
2. Shower whilst standing															
3. Use shower controls /bath temperature mixers															
4. Turn taps (<i>any in home</i>)															
5. Wash your back and neck															
6. Dry your back and neck															
7. Wash and dry your feet															
8. Wash your hair															
9. Style/ blow-dry your hair															
10. Cut/file your finger nails															
11. Take care of your feet															
Total Score: Section A =							Total Score: Section B =								

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in both sections:

A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".

B: 'How else do you do it **with** an aid/gadget or alternate method?' Fill in the middle columns. Leave B blank if you tick "no" or "have help."

5. COOKING	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1. Stand while working in the kitchen															
2. Set the table/ carry plates, cups etc															
3. Peel and chop vegetables															
4. Carry a full pan to/ from the cooker															
5. Drain water from a saucepan (e.g. vegetables, pasta)															
6. Remove heavy items (e.g. bag of sugar) from top cupboards															
7. Baking (eg. cakes, bread, pastry)															
8. Take things in/out of oven															

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: ‘How do you do it **without** using an aid/gadget, alternate method or help?’ If you do not normally do the activity, tick “not applicable”.
B: ‘How else do you do it **with** an aid/gadget or alternate method?’ Fill in the middle columns. Leave B blank if you tick “no” or “have help.”

5. COOKING (continued)	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
9.Wash up															
10.Put crockery/pans etc into kitchen cupboards															
11.Use a kettle (e.g. fill, pour)															
12.Turn cooker knobs															
13.Open fridge door															
14.Prepare and cook a snack and/or a meal															
Total Score: Section A =							Total Score: Section B =								

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in **both** sections:
A: ‘How do you do it **without** using an aid/gadget, alternate method or help?’ If you do not normally do the activity, tick “not applicable”.
B: ‘How else do you do it **with** an aid/gadget or alternate method?’ Fill in the middle columns. Leave B blank if you tick “no” or “have help.”

6.MOVING AROUND INDOORS	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Some- one does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Walk indoors (e.g. get to toilet/ bathroom; round kitchen)															
2.Open the front/ back door															
3.Lock and unlock doors															
4.Get to the front door in time to answer															
5.Get to the phone in time to answer															
6.Stand for longer periods															
7.Get up and down steps/ stairs															
8.Bend to floor/pick up items															
9.Reach up															
10.Kneel															
11.Carry heavy items around the house															
12.Manage heating (e.g. controls, woodburner, multifuel stove, open fire)															
Total Score: Section A =							Total Score: Section B =								

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in **both** sections:
A: ‘How do you do it **without** using an aid/gadget, alternate method or help?’ If you do not normally do the activity, tick “not applicable”.
B: ‘How else do you do it **with** an aid/gadget or alternate method?’ Fill in the middle columns. Leave B blank if you tick “no” or “have help.”

7. CLEANING THE HOUSE	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?			Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No	Please describe below which aid/s or other method/s you use?		Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	
1. Make the bed																
2. Dust and wipe surfaces																
3. Sweep up/ mop floor																
4. Wring out a cloth																
5. Vacuum clean																
6. Open a window																
7. Clean windows																
8. Clean the bath and/or shower																
9. Heavy housework (e.g. move furniture, take down curtains)																
Total Score: Section A =										Total Score: Section B =						

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: ‘How do you do it **without** using an aid/gadget, alternate method or help?’ If you do not normally do the activity, tick “not applicable”.
B: ‘How else do you do it **with** an aid/gadget or alternate method?’ Fill in the middle columns. Leave B blank if you tick “no” or “have help.”

8. LAUNDRY/ CLOTHES CARE	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Some- one does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Do the hand washing															
2.Use a washing machine (e.g. load and unload)															
3.Hang out washing															
4.Plug in and pull out a plug (<i>any in home</i>)															
5.Put up an ironing board															
6.Iron															
7.Do small repairs e.g. hemming, buttons															
8.Use scissors (<i>any in home</i>)															
9.Pick up pins/needles															
Total Score: Section A =							Total Score: Section B =								

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: ‘How do you do it **without** using an aid/gadget, alternate method or help?’ If you do not normally do the activity, tick “not applicable”.
B: ‘How else do you do it **with** an aid/gadget or alternate method?’ Fill in the middle columns. Leave B blank if you tick “no” or “have help.”

9. MOVING AND TRANSFERS	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Some-one does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?						
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	
1.Get into and out of bed																
2.Turn over and sit up in bed																
3.Stand up from a chair without armrests																
4.Pull up bedclothes/duvet																
5.Getting a comfortable sleeping position																
6.Sit for longer periods (e.g. in a car, train)																
Total Score: Section A =										Total Score: Section B =						

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: ‘How do you do it **without** using an aid/gadget, alternate method or help?’ If you do not normally do the activity, tick “not applicable”.
B: ‘How else do you do it **with** an aid/gadget or alternate method?’ Fill in the middle columns. Leave B blank if you tick “no” or “have help.”

10. COMMUNICATION	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1. Use a phone / mobile/ smartphone (call/ text/ any functions)															
2. Hold a book															
3. Write															
4. Handle money/ cards; use cash machine/pay by card															
5. Use a computer and mouse/ laptop/ tablet (e.g. iPad)															
6. Use remote controls (e.g. TV)															
Total Score: Section A =							Total Score: Section B =								

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in **both** sections:
A: ‘How do you do it **without** using an aid/gadget, alternate method or help?’ If you do not normally do the activity, tick “not applicable”.
B: ‘How else do you do it **with** an aid/gadget or alternate method?’ Fill in the middle columns. Leave B blank if you tick “no” or “have help.”

11. MOVING AROUND OUTSIDE/ SHOPPING	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method? Yes No			Have help/ Someone does it for	B. If yes, how else do you do it with an aid/gadget or alternate method?						
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score					Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	
1.Walk on level ground																	
2.Go for a long walk (e.g. a mile)																	
3.Go up stairs without a handrail																	
4.Travel by public transport																	
5.Get in and out of a car and open car door																	
6.Drive a car (e.g. hold steering wheel, turn car key, change gear)																	
7.Fill the car with petrol																	
8.Open a heavy (e.g. shop) door																	
9.Walk around the shops																	
10.Carry shopping																	
11.Do the weekly shopping																	
12.Hold a walking stick																	
13.Use a mobility scooter																	
Total Score: Section A =											Total Score: Section B =						

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in both sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?' Fill in the middle columns. Leave B blank if you tick "no" or "have help."

12. GARDENING / HOUSEHOLD MAINTENANCE	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Some- one does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes No			Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Change a light bulb															
2.Light gardening (e.g. weed, prune, plant)															
3.Heavy gardening (e.g. dig, mow)															
4.Climb ladders															
5.Clean the car (inside and out)															
6.Do household repairs															
7.Car maintenance (eg oil, water)															
Total Score: Section A =									Total Score: Section B =						

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in both sections:

A: 'How do you do it without using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".

B: 'How else do you do it with an aid/gadget or alternate method?' Fill in the middle columns. Leave B blank if you tick "no" or "have help."

13. CARING	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Feed a child, prepare bottles															
2.Bathe a child/ change nappies															
3.Dress a child															
4.Do a child's hair															
5.Use children's equipment (e.g. high chair, push chair, car seat)															
6.Put a child in/ out of high chair, push chair, high seat															
7.Lift and carry a child															
8.Play with children															
9.Care for others (e.g. elderly relatives)															
Total Score: Section A =									Total Score: Section B =						

Please tick (✓) to indicate your ability carrying out the activities listed below during the last two weeks. Please fill in both sections:

A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".

B: 'How else do you do it **with** an aid/gadget or alternate method?' Fill in the middle columns. Leave B blank if you tick "no" or "have help."

14. HOBBIES, LEISURE & SOCIAL ACTIVITIES	A. How do you do it without an aid/ gadget, alternate method or help?						Do you use an aid or other method?		Have help/ Someone does it for me	B. If yes, how else do you do it with an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	Yes	No		Please describe below which aid/s or other method/s you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Crafts (e.g. knitting, crochet, sewing, embroidery, model making)															
2.Do-It-Yourself (e.g. using tools, decorating)															
3.Visit friends/ socialising (eg pub, cinema, theatre)															
4.Attend community / religious groups or classes															
5.Physical activities (e.g. dance, active sports, swimming, bicycling, fishing)															
6.Quiet recreation (e.g. painting, cards)															
7.Performing arts (e.g. music, choir, dramatics)															
8.Pet care (eg feed, groom)															
9.Take dog for a walk (e.g. hold leash)															
Total Score: Section A =							Total Score: Section B =								

PART THREE: USING AIDS/ GADGETS

Please Tick (✓) the aids/gadgets you have and then when you use them. If you have any aids/gadgets which you do not use, please give the reason.

Do you have one?		How often use?			If do not use it—why not?			
Aid/Gadget	Have at home	Use often	Only if in pain	Do not use	Doesn't work	Heavy	Ugly	Poor grip
<u>1. Eating/Drinking</u>								
Adapted cutlery								
Light glass/mug/cup								
Angled bread knife or saw								
Cheese slicer								
Bottle/jar opener								
Easy-grip serving tongs								
<u>2. In the Bathroom/</u>								
Raised toilet seat								
Toilet frame								
Tap turner/ lever taps								
Tube squeezer								
Long handled comb								
Medicine bottle opener								
Bidet								
Grab rail								
<u>3. Getting Dressed</u>								
Dressing stick								
Zip pull								
Sock/ tights aids								
Long handled shoe horn								

Please Tick (✓) the aids/gadgets you have and then when you use them. If you have any aids/gadgets which you do not use, please give the reason.

Do you have one?		How often use?			If do not use it—why not?			
Aid/Gadget	Have at home	Use often	Only if in pain	Do not use	Doesn't work	Heavy	Ugly	Poor grip
<u>4. Bath/Shower</u>								
Bath board								
Bath seat								
Grab handle								
Long handled sponge								
Turner for shower knobs / bath temperature controls								
Shower stool/chair								
Electric toothbrush								
<u>5. Cooking</u>								
Perching stool								
Trolley								
Easy potato peeler								
Vegetable basket								
Easy can opener (e.g. electric/battery)								
Non-slip mat for worktops								
Kettle tipper								
Ring pull can opener								
Spike board								
<u>6-8. General</u>								
Key turner								
Yale knob turner								
General knob turner								
Easy-grip scissors								
Helping Hand (long handled grabber)								

Please Tick (✓) the aids/gadgets you have and then when you use them. If you have any aids/gadgets which you do not use, please give the reason.

Do you have one?		How often do you use?			If you do not use – why not?			
Aid/Gadget	Have at home	Use often	Only if in pain	Do not use	Doesn't work	Heavy	Ugly	Poor grip
<u>9. Moving and Transfers</u>								
Raised seat cushion/ chair blocks								
Bed blocks								
Bed backrest								
Electric bed/mattress raise								
Bed handle (to help in/out)								
<u>10. Communication</u>								
Reading table or book rest								
Pen grip								
<u>11. Moving round outdoors/ shopping</u>								
Walking stick/ crutch/walking frame								
Shopping trolley								
Mobility scooter								
Wheelchair								
Shoe insoles								
<u>Other</u>								
Wrist splint								
Walking stick								
Any other gadgets? (eg for Caring; Household Maintenance; Leisure)								

Finally:

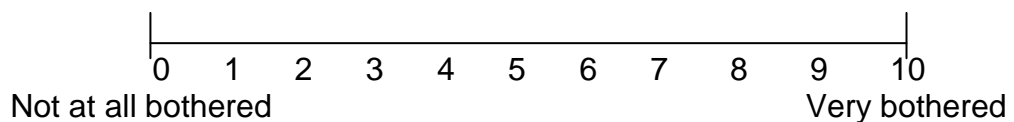
1. Do you use / wear (*please tick if applicable*):

Wrist splint/s ☐ Walking aid ☐ Shoe insole/s ☐

Any other splint/s ☐ Please state: _____ Knee brace ☐

2. Overall, which aids/gadgets you own do you value the most?

3. How do you feel about using aids/gadgets? (*please circle the number*)



4. What do you do yourself to help self-manage your symptoms/ condition?

5. What is the most important thing you want to continue to do in life or to manage?

If there is anything else you would like to tell us, or if you have any other comments, please write below:

Thank you for completing the EDAQ. Please check you have not missed any questions or pages.

Office Use only:

Name: _____

Date: ____/____/____

EDAQ Domain scores

	Domain	Section A Total Score	Section B Total Score	Difference: B-A
1	Eating/ Drinking			
2	In the Bathroom/ Personal Care			
3	Getting Dressed/ Undressed			
4	Bathing/ Showering			
5	Cooking			
6	Moving around Indoors			
7	Cleaning the House			
8	Laundry/ Clothes Care			
9	Moving & Transfers			
10	Communication			
11	Moving around Outdoors/ Shopping			
12	Gardening/ Household Maintenance			
13	Caring			
14	Hobbies, Leisure & Social Activities			
	SELF-CARE Score Domains: 1+2+3+5+7+8+10			
	MOBILITY/ PARTICIPATION Score Domains: 4+6+9+11+12			

(See EDAQ Manual v2 for scoring information).